Journal of Forensic and Legal Medicine 19 (2012) 35–39

Contents lists available at SciVerse ScienceDirect

Journal of Forensic and Legal Medicine

journal homepage: www.elsevier.com/locate/jflm

Short report

Psychological profiles of adult sexual assault victims

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ARTICLE INFO

Article history:
Received 12 May 2011
Accepted 3 October 2011
Available online 6 November 2011

Keywords:
Victimization
Sexual assault
Victim profile
Vulnerability
Mental illness

ABSTRACT

This is a retrospective analysis of the psychological and psychiatric history of adult patients who attended the Lancashire Sexual Assault and Forensic Examination Centre between April 1st 2010 and March 31st 2011 for forensic examination. During this time 269 adults attended for forensic examination; the records of these patients were audited for evidence of psychological or psychiatric ill health. Affective disorders were disclosed in 48.7% of cases (depression, depression and anxiety, anxiety, bipolar affective disorder) and 3.0% declared having been diagnosed with a psychotic illness (schizophrenia, psychotic illness, psychotic behaviour). Furthermore, deliberate self-harm was disclosed by 29.4% of complainants and 22.3% of attendees had attempted suicide at least once in their lifetime. This study highlights increased prevalence of mental illness in sexual assault complainants which contributes to increased states of vulnerability. This and further similar research efforts have a role to influence prevention schemes, management strategies and healthcare planning for those individuals who are sexually assaulted.

1. Introduction

The British Crime Survey (BCS) is an independent report conducted each year by interviewing 46,000 people over the age 16 in England and Wales.[12] The 2009/2010 BCS reported that one in five females and one in fifty males had experienced some form of sexual assault (including attempts) at least once since the age of 16. In the year prior to the survey, 2% of women and <1% of men had experienced an incident of sexual assault.[11]

The Lancashire Sexual Assault and Forensic Examination (SAFE) centre was opened in 2002 in the grounds of Royal Preston Hospital to provide a comfortable, secure and forensically clean environment to support both the medical and forensic needs of sexual assault victims. It is Britain's first purpose-built centre which provides forensic medical examination, counselling and advice after sexual assault, as well as support and assistance through criminal proceedings which may follow.[8] Ongoing analysis of the data collected by the SAFE centre from sexual assault victims may shed light on not only the prevalence of reported sexual crimes in the serviced areas but also the details of the acts themselves and if there is any opportunity to tailor services provided to the specific needs of the community. Importantly, this audit looks at the prodrome to sexual assault, specifically whether psychiatric and psychological ill health may contribute to the victim profile. Understanding of the types of individuals targeted for these crimes may pave the way for improved specialised counselling services and follow-up.

Victimisation is an understudied area, particularly when compared to studies which analyse the sequelae after assault. This trend is no different across sexual crimes; with vast amounts of research targeting psychological and psychiatric sequelae post event. Sexual assault is often used as a variable of prediction for later ill health.[5,13] This study aims to identify and describe a trend in the psychological and psychiatric backgrounds of individuals subject to sexual assault which may increase their vulnerability.

Parameters identified during the study include depression, psychotic illness, learning disability, and deliberate self-harm and attempted suicide. These factors are discussed further to understand the relationship between mental illness and vulnerability.

Vulnerability describes an individual's susceptibility to being open to physical or emotional harm, criticism or temptation.[4] Vulnerability is created by an interaction between a person, including variables such as age, sex and gender as well as physical

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1752-928X/$ – see front matter
doi:10.1016/j.jflm.2011.10.007

size and fitness and psychological well being, and the environment. The BCS reported that women with highest risk of sexual assault were aged between 16 and 19 years when compared with older age groups[11] but very little information is available with regards to why these women are targeted. Vulnerability in mental illness is another area with substantial amounts of speculation and perceived understanding despite a clear lack of evidence. Baroness Stern recognises the link between mental health problems and learning disabilities and increased vulnerability in her 2010 review. She emphasizes those with mental health problems are more likely to become 'repeat victims'.[12] Other contributors to vulnerability discussed are history of abusive relationships, young age, difficult backgrounds, housing within a care home, as well as excessive alcohol use. Baroness Stern emphasizes that vulnerability, by any means, decreases an individual's capacity to consent.[12]

Depression will affect 8% of individuals during their lifetime.[7] Categorised by anhedonia, low energy and low mood, depressive illnesses are often associated with biological and psychological symptoms which may increase a depressed individual's vulnerability. Feelings of hopelessness and worthlessness and difficulty making decisions may decrease an individual's willingness and ability to identify and respond appropriately to potentially threatening situations. Parallel to this, Acierno et al. found that individuals with active depressive illness were at increased risk of being physically assaulted.[1]

Psychotic illnesses are often explained by describing a lack of ability to identify and differentiate reality. The most common of this subtype of psychiatric illness is schizophrenia, affecting 1% of the population.[7] Schizophrenia, a disorder of thoughts, perceptions and behaviours, may influence sexual assault by impairing the affected individual's perception and understanding of the attack or environmental and personal circumstances which may put them at risk.

Weinhardt et al. conducted a review of the debilitating nature of severe and persistent mental illness (SPMI), including both severe depressive and psychotic illnesses. This literature analysed by this group revealed that up to 76% of women with SPMI had been sexually assaulted at least once in their life.[14]

Although not strictly considered a mental health issue, *learning disabilities* can share signs and symptoms of mental illness which increase vulnerability. Tharinger et al. recognise a growing understanding of the vulnerability of individuals with disabilities (of any nature) to sexual abuse.[13] While the term *'learning disability'* covers ranging severities of impairment of cognition, there are several characteristics which may or may not be present that potentially increase vulnerability and therefore the likelihood of sexual assault. Namely, dependency on caregivers, reduced or absent verbal abilities, questing for social acceptance as well as emotional insecurities. In addition, Tharinger et al. consider that this specialised population may not receive adequate education in relation to sexuality and privacy further amplifying their risk.[13]

Deliberate self-harm is common, and a potentially fatal sign of underlying psychological disturbance and distress. The National Interview Survey indicated that between 4.6 and 6.6% of the surveyed British population had self-harmed at least once in their lifetime.[9] In 2009 there were 5675 completed suicides in the United Kingdom.[10] Although not diagnoses themselves, deliberate self-harm and suicide reflects a combination of distress and adverse coping mechanisms, stressing underlying psychopathology, and requirement for treatment of mental illness.[2,6] Self-harm is a very potent predictor for later completed suicide, with 10% of those presenting to hospital after an episode of self-harm committing suicide within the following 10 years. A concurrent diagnosis of depression hastens this figure.[2] This group of individuals who are motivated to harm themselves are considerably vulnerable to sexual assault by likely not being mindful of keeping themselves safe.

2. Aim

To identify whether there is a trend in the psychological and psychiatric backgrounds of individuals who are sexually assaulted which contributes to a state of increased vulnerability.

3. Importance of study

Identification of psychological and psychiatric issues in the individuals attending for forensic examination may reveal specific psychological and psychiatric risk factors for sexual assault. Identification of a vulnerable group of people provides a direction at which primary prevention tactics can be targeted and increased, specialised levels of mental health support after the event.

4. Standard

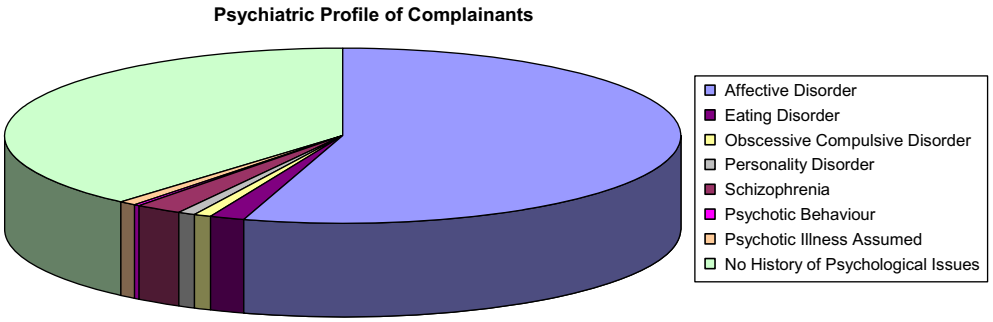
To conduct a review of all adult ($\geq$18years) patients who attended the SAFE centre between 1st of April 2010 and the 31st of March 2011 to identify reported personal psychological and psychiatric information.

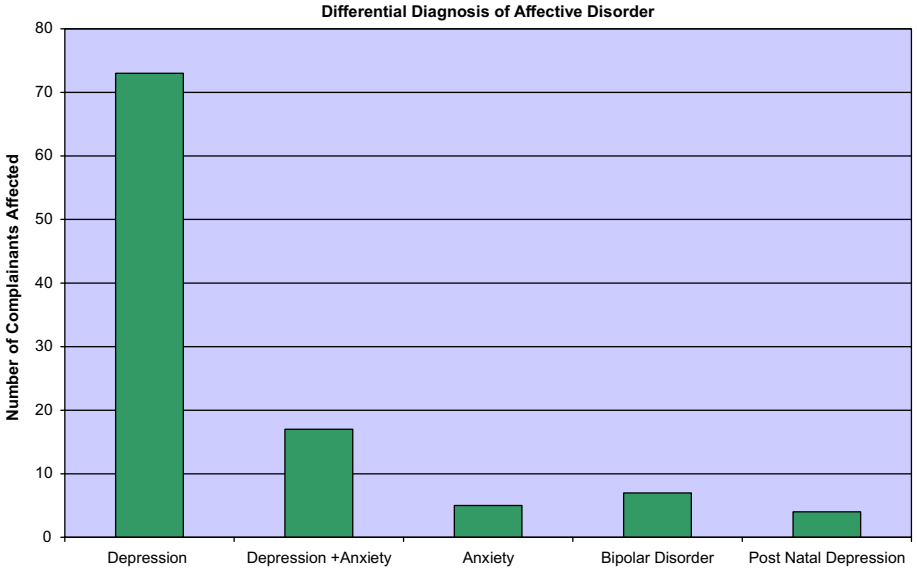
5. Methods

Patients who attended the SAFE Centre between the dates April 1st 2010 and March 31st 2011 (12 month period) were identified using the SAFE Centre log book (record of all attendees organised by date and unique SAFE Centre identification number). All clients aged 18 years old and above at the time of alleged incident who received a forensic examination were included in the study. Patient consent for participation in this study was obtained at the time of forensic examination where patients have the opportunity to consent for their anonymous details to be used for training and research purposes. Individual patient's SAFE Centre notes, which include a medical history proforma, were retrieved and analysed for reports of diagnosed psychological or psychiatric illness, disclosure of deliberate self-harm and attempted suicide, as well as indicated treatment of mental health conditions. Specifics recorded from the notes included:

- antidepressant medication
- anti-psychotic medication
- history of/current deliberate self-harm
- history of suicide attempt
- diagnosis of affective disorder
- diagnosis of psychotic illness
- evidence of learning disability
- disclosure of previous sexual assault
- reports of previous or current use of counselling or mental health services

For the purposes of this study those notes which recorded use of antidepressant medication without a diagnosis, 'depression' was assumed. Likewise, individuals on anti-psychotic medication without a recorded diagnosis are labelled 'assumed psychotic illness' in the study. Results were formulated.





6. Limitations

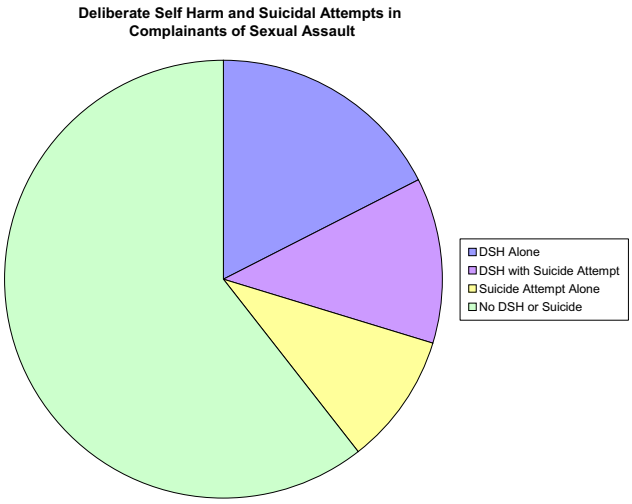
It is important to analyse variables which may influence the results of this study. The data was collected from a years' worth of patients, and more robust findings may be identified if a greater sample was analysed. The medical history proforma created by the SAFE centre was used to identify psychological and psychiatric illness in place of a specifically designed questionnaire. These forms include areas for medications, history of mental illness or deliberate self-harm to be recorded however, the data collected was heavily reliant on the interviewers' skill and attention to detail in these areas as well as the client's wiliness to participate. Additionally, mental illness was self-reported and therefore relies on the victims' understanding and insight into their own mental health. It is recognised mental health is a sensitive topic of discussion at a particularly harrowing time, after experiencing a sexual assault. Patients are informed during the consent process that any disclosures made in the SAFE centre may be included in a court document; allowances must be made for inaccuracy of patient recall or unwillingness to disclose. Of the data collected, no correction was made for socioeconomic status, and the variables as listed in the methods were all considered independently except where specified. Furthermore all data collected was from the exclusive notes of the SAFE centre taken at the time of forensic examination, confirmation of mental illness diagnosis or absence was not made using additional patient records.

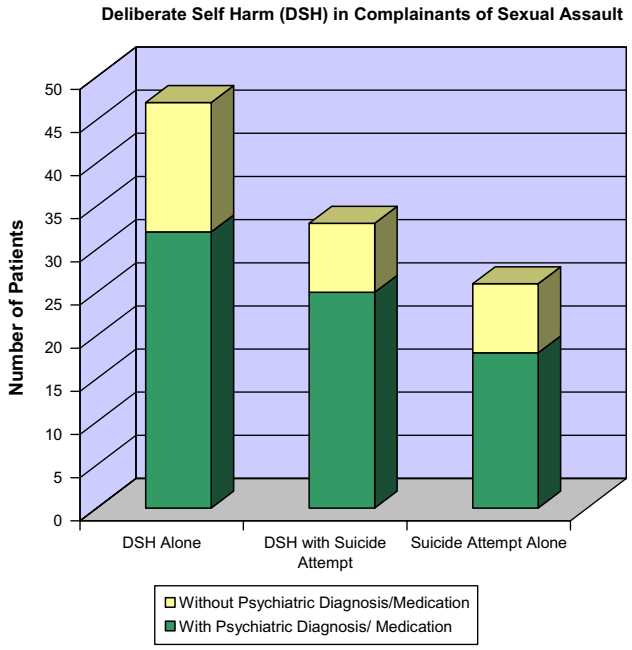
7. Results

Using the SAFE centre log book, 269 patients were identified for analysis using the above criteria. All 269 patients were audited of which 94.8% ($n = 255$) patients were new referrals and 5.2% of individuals had attended the Lancashire SAFE centre at least one time in the past. Of the identified patients, 48.7% ($n = 131$) reported being previously diagnosed with an affective disorder (depression, depression and anxiety, anxiety, bipolar affective disorder) and 3.0% ($n = 8$) had been diagnosed with a psychotic illness (schizophrenia, psychotic illness, psychotic behaviour).

In addition, four individuals reported having an eating disorder, two had been diagnosed with Obsessive Compulsive Disorder and two complainants carried a diagnosis of Borderline Personality Disorder. Of the entire population, 27.5% ($n = 74$) said they were prescribed one type of antidepressant medication (Citalopram, Fluoxetine, Mirtazepine, Sertraline, Paroxetine, Venlafaxine, Amitriptyline, Unknown) and 4.5% ($n = 12$) were on at least one anti-psychotic medication (Quetiapine, Risperidone, Depixol Injection, Clozepine, Aripiprazole).

History of deliberate self-harm (DSH) was reported by 29.4% of complainants and 22.3% of attendees had attempted suicide at least once in their lifetime. Of those who had self harmed and/or attempted suicide (39.4% of total population), 70.8% had a psychiatric diagnosis or medication prescribed to them.





Although severity or formal assessment was not available, learning difficulty or disability was described in 5.6% of cases. History of sexual assault was explicitly documented in 8.2% of attendees despite lack of dedication to question in the history proforma. Overall, 34.2% of the audited population was revealed to have no evidence of psychological or psychiatric issues.

8. Discussion

In summary, 65.8% of adult complainants of sexual assault who attended the Lancashire SAFE centre demonstrated some indication of psychological or psychiatric illness. Affective disorders were confirmed in 48.7% of complainants and 3% of the total population disclosed psychotic illnesses. Deliberate self-harm was reported by 29.4% of complainants and a staggering 22.3% had a history of attempted suicide. Furthermore, 5.6% of cases claimed some type of learning difficulty or disability. These results consistently show increased prevalence of psychiatric illness amongst those individuals who are sexually assaulted when compared to the general population.

The results of this study are consistent with a similar study by Campbell et al. who also found increased prevalence of mental health problems and deliberate self-harm amongst individuals who attended a North East London sexual assault referral over one year. In part one of the study which used a similar medical history proforma to that of this study, 21% disclosed having a psychiatric history, 24% of attendees reported deliberate self-harm and 8% identified learning disabilities.[3] Furthermore, the group identified increased reporting of mental health problems when a series of screening and risk assessment questions were added during the latter part of the study. The results yielded by the additional screening tools prompted 4% of patients to have urgent follow-up and 3% to be immediately referred to the psychiatric liaison team.[3]

The results of the above study combine with the results of the current study showcase important information not previously recognised.

Mentally ill individuals are more vulnerable to sexual assault than the unaffected population; this is supported by the characteristics of mental illness and literature as outlined previously, as well as the dramatically increased prevalence of mental illness in those individuals who present to sexual assault referral centres. Identifying this high-risk community of people is advantageous for the targeting of prevention and education schemes as well as specialisation of after-care provided.

There is a distinct lack of evidence in this particular field of sexual victim profiles, however further research is important because similar findings could very well influence prevention schemes, management strategies and healthcare planning.

Areas to develop alongside this study include analysis of the role which treatment of psychiatric illness plays in decreasing the risk associated with this group of vulnerable people. Recognition of the results demonstrated in this study by forensic examiners should highlight the increased incidence of mental illness as well as the importance of risk assessment at the time of examination and potential responsibility of referring patients to mental health services. Development of mental health assessment tools and management pathways in sexual assault referral centres would markedly increase patient safety. This study should raise awareness of staff within sexual assault referral centres possibly instigating additional mental health and risk assessment training for staff. Adaptation and further development of specialist services available to sexual assault victims may in turn lead to a change in the psychological and psychiatric sequelae demonstrated after sexual assault.[5,13]

9. Conclusion

Victimisation is an understudied area, but the results of this study demonstrate reason for further investigation of the vulnerability of sexual assault victims. Mental illness and deliberate self-harm are at increased prevalence within the sexually assaulted community and contribute to their vulnerability. Identification of risk factors for sexual assault may, in the future, influence the design and initiation of prevention campaigns, management strategies and healthcare planning which target the specific needs of the community.

Conflict of interest

The authors do not declare any conflict of interest.

Funding

None declared.

Ethical approval

None declared.

Acknowledgements

All SAFE Centre staff for their helpful participation and support.

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